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No. 01-1840

In The

Supreme Court of the United States

October Term, 2002

DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN,

Petitioner,

v.

FRANK REGULA,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF THE ERISA INDUSTRY COMMITTEE FOR LEAVE TO FILE AND BRIEF AMICUS CURIAE IN SUPPORT OF THE PETITION FOR CERTIORARI

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MOTION OF THE ERISA INDUSTRY COMMITTEE FOR LEAVE TO FILE A BRIEF AMICUS CURIAE IN SUPPORT OF THE PETITION FOR CERTIORARI

The ERISA Industry Committee ("ERIC") moves, pursuant to Rule 37.2, for leave to file the attached brief *amicus curiae* in support of the petition for writ of certiorari in this case. While the petitioner has consented to the filing of this brief, respondent Frank Regula has not consented. Correspondence reflecting the consent of the petitioner has been lodged with the Court.

ERIC is a nonprofit organization representing America's largest private employers that maintain ERISA-covered pension, healthcare, disability, and other employee benefit plans, providing benefits to millions of active workers, retired persons, and their families nationwide. All of ERIC's members do business in more than one State, and many have employees in all fifty States. ERIC frequently participates as amicus in cases with the potential for far-reaching effect on employee benefit plan design or administration.[1]

ERIC and its members have a vital interest in this case, which will affect in two ways how claims for benefits are administered. First, the decision below imports into the disability plans administered by private employers the "treating physician rule" used in determining disability claims under Titles II and XVI of the Social Security Act. Second, it holds that if a company's employees serve on a committee deciding benefit claims, there is a per se conflict of interest. Both holdings deprive employers of the discretion afforded them under ERISA with respect to plan design and plan administration. If allowed to stand, the decision below will cause additional expense in the administration of plans, to the detriment of both employers and employees, and will create uncertainty by imposing different rules in the Ninth Circuit than elsewhere in the country.

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[1] *See, e.g., Hughes Aircraft Co. v. Jacobson,* 525 U.S. 432 (1999); *Lockheed Corp. v. Spink,* 517 U.S. 882 (1996); *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989); *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58 (1987).

Because of the importance of these issues to ERIC and its members, ERIC moves for leave to file this brief to assist the Court in its consideration of the petition.

Respectfully submitted,

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BRIEF OF THE ERISA INDUSTRY COMMITTEE AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR CERTIORARI

The ERISA Industry Committee ("ERIC") respectfully submits this brief *amicus curiae* in support of the petition for a writ of certiorari in this case.[1]

INTEREST OF AMICUS CURIAE

The interest of ERIC and its members is set forth in the foregoing Motion for Leave to File.

INTRODUCTION

Both questions presented in the petition for certiorari raise important issues of ERISA interpretation that affect how benefit plans are administered—issues on which the courts are divided and with respect to which the Ninth Circuit opinion cannot be reconciled with the statute and implementing regulations. The court of appeals' ruling below improperly circumscribes the broad discretion ERISA accords to private employers to design and administer the disability benefit plans that they offer to their employees. If allowed to stand, the decision below is sure to create additional expense in the administration of plans, to the detriment of both the employers and employees whose contributions fund them.

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[1] Pursuant to Rule 37.6, amicus states that no counsel for any petitioner or respondent authored this brief in whole or in part. No person or entity, other than ERIC and its members, made a monetary contribution to the preparation or submission of this brief.

The Department of Labor has recently completed a major review and overhaul of its regulations governing claims procedures for group health and disability plans, including the process for review of adverse benefit determinations and the need for medical consultations. Those regulations strive to reconcile "the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered." 65 Fed. Reg. 70246, 70246 (Nov. 21, 2000). The newly promulgated rules do not require plans to defer to a claimant's treating physician, nor do they prohibit the employees of a plan sponsor from serving on the benefit committees that review claims. Nonetheless, the decision below has effectively rewritten the governing standards—at least for States in the Ninth Circuit—to include both of those provisions. The result is not only inconsistent with ERISA but it subjects plans to differing standards depending on the court reviewing the claim, contrary to the statute's commitment to uniform national standards.

STATEMENT

1. The Employee Retirement Income Security Act ("ERISA") was enacted in 1974 to "safeguar[d] . . . the establishment, operation, and administration" of employee benefit plans by setting "minimum standards . . . assuring the equitable character of such plans and their financial soundness." 29 U.S.C. 1001(a). The statute does not require employers to establish employee benefit plans, nor does it define the benefits that must be provided or the method of calculating those benefits. *See Lockheed v. Spink*, 517 U.S. 882, 885 (1996); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981). Instead, ERISA regulates employers that choose to offer employee benefits to ensure that

employees actually receive the benefits described in their plans. In furtherance of that goal, Section 503 of ERISA delegates to the Department of Labor the authority to promulgate rules that will "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." ERISA § 503, 29 U.S.C. § 1133.

Pursuant to Section 503, the Department of Labor recently overhauled the regulations governing the processing of benefit claims under ERISA-covered disability plans, effective for all claims filed after January 1, 2002. *See* 65 Fed. Reg. at 70246. The new standards for handling disability claims are "intended and expected to improve the timeliness and accuracy of disability benefit claims determinations," "increase enrollee confidence in disability plans," and "promote efficiency in disability insurance and labor markets." *Id.* at 70261. As a general rule, an ERISA-covered disability plan must "contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." *Id.* at 70266.

Among other things, the new rules provide that a claimant must have (i) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits; (ii) reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, upon request and free of charge; and (iii) a review that takes into account all comments, documents, records, and other information

submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. 29 C.F.R. § 2560.503-1(h)(4).

In addition, claimants have the right to appeal an adverse benefit determination to an appropriate named fiduciary of the plan. If the determination is based "in whole or in part on a medical judgment," the fiduciary must "consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." A consulting health care professional cannot have been consulted in connection with the adverse benefit determination that is the subject of the appeal, nor be the subordinate of any such individual. 29 C.F.R. § 2560-503-1(h)(3)(iv-v).

2. According to the Department of Labor, 36 million U.S. private-sector employees (or 32 percent of all such employees) are insured against short-term disability through employer-sponsored plans, and 26 million (or 23 percent) are insured against long-term disability. 65 Fed. Reg. at 70261. The Department of Labor also estimates that there are some 1,716,000 disability plans operating in the United States, and that together they process 1,389,700 claims a year, of which the overwhelming majority (1,304,900) are approved. *Id.* at 70263.

3. Separate and apart from private employer-sponsored disability plans, there are a number of government disability programs, including Social Security Disability Insurance ("SSDI") and Supplemental Security Income ("SSI"), both of which are administered by the Social Security Administration ("SSA").

SSDI is a component of the Social Security Old-Age, Survivors, and Disability Insurance ("OASDI") program. *See* Title II of the Social Security Act; 42 U.S.C. §§ 401 - 433. The program is financed by employer and employee payroll taxes. SSDI coverage is widespread with approximately 90 percent of workers aged 21 to 62 protected in the event of long-term severe disability. *See* OASDI Fact Sheet (visited June 30, 2002) <http://www.ssa.gov/OACT/FACTS/fs2002_06.html>. In calendar year 2001, approximately 1.5 million claims for disability benefits were filed, with benefits being awarded in 46.1 percent of cases. *See* Selected Data from Social Security's Disability Program (visited July 16, 2002) <http:// www.ssa.gov/OACT/STATS/dibStat.html>.

SSI is a nationwide federal assistance program that guarantees a minimum level of income for needy aged, blind, or disabled individuals without regard to past contribution. *See* Title XVI of the Social Security Act; 42 U.S.C. §§ 1381 - 1383d. In calendar year 2001, there were approximately 1.5 million new applications and 665,000 new entrants for benefits based on blindness or disability. *See* 2002 SSI Annual Report (visited July 16, 2002) <http://www.ssa.gov/OACT/SSIR/SSI02/Participants_1.html#405005>.

For both SSDI and SSI, determinations of disability are made based on a five-step sequential evaluation process set forth in SSA regulations. *See* 20 C.F.R. §§ 404.1520, 416.920. Both programs also adhere to the following principle, known as the "treating physician rule":

> Generally, we give more weight to opinions from your treating sources . . . . If we find that a treating source's opinion on the issue(s)

> of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply [various factors presented in the regulations] in determining the weight to give the opinion.

20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2).[2]

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[2] The "treating physician" rule originated in the courts reviewing appeals from SSA determinations, and was premised on the Social Security Act being "a remedial statute, to be broadly construed and liberally applied." *Gold v. Secretary of Health, Educ. and Welfare*, 463 F.2d 38, 41 (2d Cir. 1972) (quoting *Haberman v. Finch*, 418 F.2d 664, 667 (2d Cir. 1969)). It was adopted by the SSA only upon injunction from the U.S. Court of Appeals for the Second Circuit. *See Schisler v. Sullivan*, 3 F.3d 563, 567-68 (2d Cir. 1993) (reciting history).

REASONS FOR GRANTING THE WRIT

I. The Decision Below Creates A Division in The Lower Courts, Uncertainty in Plan Administration, And Questionable Precedent That Calls For Immediate Review By This Court.

A. The Ninth Circuit's Importation of the SSA's Treating Physician Rule Into ERISA Is Improper and In Conflict With Other Circuits.

In the decision below, the panel majority, desirous of "consistency in [its] review of disability determinations" could find "no reason why the treating physician rule should not be used under ERISA." *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001). That is tantamount to declaring that for the convenience of the court, all apples shall henceforth be considered as oranges. While both ERISA and the SSA involve disability programs subject to federal court review, their statutory and regulatory schemes are by no means interchangeable, and the presumptions that apply to one are inappropriate for the other.

The overriding principle of ERISA is that benefits are governed by the language of the plan itself. *See Firestone*, 489 U.S. at 115. Requiring all employers to abide by the treating physician rule despite the uniqueness of each plan is precisely what ERISA is not intended to do. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985) (ERISA does not "regulate the substantive content of welfare-benefit plans."). ERISA neither contemplates nor requires a mandatory application of the

treating physician rule. Rather, ERISA requires basic procedural safeguards in the determination of benefit plans and appeals. *See* 29 U.S.C. § 1133.

ERISA does give the Department of Labor the authority to promulgate general regulations governing the processing of benefit claims, including disability claims. Those regulations, just recently updated, do not impose a treating physician standard, although the Department is clearly familiar with the rule since it adopted that standard for Black Lung cases in regulations published just a few weeks later. *See* 65 Fed. Reg. 79920 (Dec. 20, 2000). Instead, the Department requires consultation with "an appropriate health care professional." 29 C.F.R. § 2560-503-1(h)(3)(iv-v). Subsequent guidelines issued by the Department explain that the requirement of consultation "is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues." The guidelines go on to state that "[i]n all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, *weighing the advice and information so obtained*, and making an *independent* decision on the appeal." Benefit Claims Procedure Regulation FAQ, U.S. Dept. of Labor Q-D8 ("BCPR") (visited July 16, 2002) <http://www.dol.gov/pwba/FAQs/faq_claims_proc_reg.html > (emphasis added).

The Department has concluded that its regulation strikes the appropriate balance between the need for "accuracy," "enrollee confidence in disability plans," and "efficiency in disability insurance and labor markets." 65 Fed. Reg. at 70261. As its subsequent guidance explains:

> The Department did not intend to prescribe any particular process or safeguard to ensure and verify consistent decision making by plans. To the contrary, the Department intended to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with the prudent administration of a plan.

BCPR Q-B4 (visited July 16, 2002) <http://www.dol.gov/pwba/FAQs/faq_claims_proc_reg.html>.

The Department of Labor's interpretation of the proper balance between plan flexibility and required procedures is instructive, even though the particular claim at issue was processed prior to the new regulations being in effect. As one of the agencies tasked with implementing ERISA, the Department's reasonable interpretation of the procedures necessary for claims processing are entitled to deference. *See Massachusetts v. Morash*, 490 U.S. 107, 116 (1989). The Ninth Circuit has now usurped the flexibility that the Department of Labor sought to protect by requiring plans to accept the opinion of a claimant's treating source as presumptively correct rather than, for example, basing a decision on the totality of the record. A departure from this flexibility that requires application of the treating physician rule in all cases is certain to create additional expense in plan administrative costs.[3]

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[3] These costs are not borne solely by employers. Because of the favorable tax consequences to benefit recipients, many disability plans are funded through after-tax employee

Although the panel majority could see "no reason" not to import the treating physician rule into its review of claims brought under ERISA, one need look no farther than the difference between the SSDI and SSI government plans—which are "to be broadly construed and liberally applied," *Gold v. Secretary of HEW*, 463 F.2d 38, 41 (2d Cir. 1972)—and the discretion ERISA accords employers to design their own plans. In a similar context, the New York Court of Appeals held that application of the treating physician rule would be inappropriate in the Medicaid program because that program "confers broad discretion on participating States to determine the extent of services provided." *See Kuppersmith v. Dowling*, 710 N.E.2d 660, 662 (N.Y. 1999). Accordingly, the court rejected a class challenge to State Medicaid regulations on the ground that they did not accord sufficient weight to treating physicians' assessment of the scope of home health care services that must be provided in specific cases.

Similarly, in *White v. Principi*, 243 F.3d 1378, 1379 (Fed. Cir. 2001), the Federal Circuit rejected the argument that the Court of Appeals for Veterans Claims had "erred as a matter of law when it failed to adopt the 'treating physician' rule, which would require that additional evidentiary weight be given to the opinion of a physician who had treated her husband." The Federal Circuit found that the treating physician rule was "specifically designed" to address conflicts of opinion inherent in the Social Security disability determination process. *See id.* at 1380. Moreover, the court found that while the treating physician rule was

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contributions. *See* Ken McDonnell, *Disability Income: Voluntary Employment-Based Plans* 9 (EBRI Notes June 2002).

consistent with the statutory scheme of Social Security, according additional weight to any one factor may conflict with a statute providing that Veterans Benefits determinations should be made on the basis of entire record. *See id.* at 1381 (citing 38 U.S.C. § 7104(a)). *See also Knudsen v. Department of Health and Human Servs.*, No. 90-2067V, 1992 WL 395631, at *6-*7 (Fed. Cl. Dec. 17, 1992) (holding that treating physician rule conflicts with National Vaccine Injury Compensation Program regulations requiring fact finder to consider entire record).

As these decisions recognize, it is the structure of the program in question that should dictate application of common law presumptions. Applying that reasoning to ERISA, two circuits have considered, and rejected, application of the treating physician rule in cases involving the very same benefit plan at issue in this case. The Eighth Circuit held that the treating physician rule could not apply to the Delta plan because "the record must be evaluated as a whole." *See Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 (8th Cir. 2001); *see also Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002) (per curiam).

The rule has also been rejected in the Fourth, Fifth, and Seventh Circuits, and in the Sixth Circuit in an unpublished opinion. *See Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999); *Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641, 644 (5th Cir. 1997); *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (7th Cir. 1999); *Jackson v. Metropolitan Life*, No. 01-5028, 2001 WL 1450811, at *2 (6th Cir. Oct. 29, 2001). The Second Circuit, however, has suggested that in circumstances where the plan administrator is accorded discretion, as is the case

here, it may find application of the rule appropriate. *See Connors v. Connecticut General Life Ins. Corp.*, 272 F.3d 127, 135 n.3 (2d Cir. 2001).

Permitting the Ninth Circuit's application of the treating physician rule in reviewing ERISA-governed claims for disability benefits would undermine the need for plan and administrative uniformity that is fundamental to ERISA. Without review of this case by this Court, benefit plans such as that sponsored by Delta are likely to be construed one way in the States of the Ninth, and possibly the Second, Circuits, and another in the States of those Circuits that have explicitly rejected application of the treating physician rule to ERISA-governed disability benefit claims. For the reasons given in Part II, *infra*, the lack of uniformity creates an intolerable situation for employers with multi-state operations.

B. The Ninth Circuit's Holding That Employee Involvement in Benefit Determinations Is a Per Se Conflict Is Incorrect and In Conflict With Decisions From Other Courts.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court addressed the standard of review for actions, such as this one, in which plan participants bring suit under ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), claiming that they have been denied benefits to which they are entitled under the terms of a plan governed by ERISA. Following trust law principles, the Court held that a deferential standard of review is appropriate when the plan administrator or other fiduciary is authorized to exercise discretionary power to construe the

terms of the plan. *Id.* at 115. The Court also stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)).

The decision below exacerbates and highlights the disagreements among the federal appeals courts as to whether and to what extent the involvement of a plan sponsor's employees constitutes a conflict of interest that deprives fiduciary decisions of the *Firestone* standard of review. The court held that a substantial conflict of interest exists whenever a plan sponsor's employees participate in deciding benefit claims, and went on to hold that the decision not to endorse the opinion of the treating physician was evidence that the fiduciaries may have been acting out of self-interest. The Court concluded that it was therefore required to review the decision to discontinue benefits *de novo*, rather than applying the deferential standard called for by *Firestone*. *See* 266 F.3d at 1145.

The Ninth Circuit's extreme position—that employee administration establishes a per se conflict requiring *de novo* review of benefit denials—incorrectly applies the standard of review that was developed to address what was perceived to be an inherent conflict when an insurance company administers claims under a policy it issued. *See Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995)). The reasoning of that line of cases is that "[b]ecause an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business." *Brown v. Blue Cross and Blue Shield of Ala., Inc.*, 898 F.2d

1556, 1561 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

In contrast to other Circuits, the Ninth Circuit now applies that rule even in situations where disability coverage is funded through assets that by definition cannot revert to the employer, *see* 26 U.S.C. § 501(c)(9), 26 C.F.R. § 1.501(c)(9)-4(a),(d), as is frequently the case with employer-sponsored disability plans. *See* 2 Jeffrey D. Mamorsky, Employee Benefits Handbook ¶ 38.05[3] (1999). The Internal Revenue Code imposes a sanction of 100% if any such contributions revert to the plan sponsor. 26 U.S.C. § 4976. As the Eleventh Circuit has held in a decision involving the very same Delta plan, such funding structures "eradicate[] any alleged conflict of interest," which means that the *Firestone* standard of review should apply. *Turner*, 291 F.3d at 1273 (citing *Buckley v. Metropolitan Life*, 115 F.3d 936 (11th Cir. 1997)). Similar conclusions are reflected in decisions of the Third, Seventh, and Tenth Circuits. *See Abnathya v. Hoffmann-La Roche Inc.*, 2 F.3d 40, 45 n.5 (3d Cir. 1993); *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1097-98 (10th Cir. 1999) (citing *Woolsey v. Marion Labs., Inc.*, 934 F.2d 1452, 1459 (10th Cir. 1991)).

The decision below is not only in conflict with those of the other Circuits, it also cannot be reconciled with basic ERISA principles. ERISA expressly permits a sponsor to appoint its own officers, employees, agents, and other representatives to serve as fiduciaries, *see* 29 U.S.C. § 1108(c)(3), *Firestone*, 489 U.S. at 105, and defines the roles of administrator and fiduciary in a manner that permits employees to serve in those positions, *see* 29 U.S.C.

§ 1002(16)(A)(i-ii) (defining "plan administrator" as "person specifically so designated by the terms of the instrument" or by the plan sponsor); § 1002(21)(A) (defining "fiduciary"). Sponsor employees who serve as administrators and fiduciaries are bound to discharge their duties solely in the interest of participants and beneficiaries. 29 U.S.C. § 1104(a). In exercising those responsibilities, among other things, employers and employees called upon to make or review benefit determinations must ensure that plan provisions are "applied consistently with respect to similarly situated claimants" and must follow the new Department of Labor regulations requiring consultation with an appropriate health care professional. 29 C.F.R. § 2560-503.1(h)(3).[4]

The Court should grant certiorari in order to re-establish uniformity among the Circuits and to articulate a standard of review that, unlike the decision below, is consistent with ERISA, its implementing regulations, and this Court's precedents.

II. ERISA's Goal of National Uniformity Cannot Be Met As Long As Employers Are Subject to Conflicting Standards.

The Court should not await further development of these issues among the courts of appeals, because the decision below has already resulted in an untenable lack of

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[4] Courts have also recognized that employers have economic incentives to provide the benefits set forth in their plan. *See Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996). Tne fact that most disability benefit claims for employer plans are approved, while most claims for SSDI and SSI benefits are not, suggests that these incentives are effective. *See supra* pp. 4, 5.

consistency for employers that administer multi-state benefit plans. The importance of national uniformity in ERISA plan regulation is acute. Without it, employers cannot provide a uniform system of benefits to their workforce. Until this Court resolves the conflict among the lower courts, employers cannot have any confidence that benefit determinations will be treated uniformly in the various States in which they have operations.

This Court has repeatedly stated that one of the primary purposes behind ERISA's enactment was to achieve uniformity in pension plan regulation. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (holding that ERISA's preemption provision "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law" and that "[o]therwise, the inefficiencies created could work to the detriment of plan beneficiaries"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983) ("By establishing benefit plan regulation 'as exclusively a federal concern,' Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees.") (citation omitted). On the questions presented in this case, the patchwork system of regulation that Congress sought to avoid with ERISA's enactment is continuing, not because of varying state laws but because of different interpretations of federal law advanced in the federal circuit courts.

The court of appeals' adoption of the treating physician rule and its application of a heightened standard of review based on employee-administered plans undermine ERISA's goal of creating a "uniform administrative scheme." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); H.R. Rep. No 93-533, at 12 (1974), *reprinted in*

1974 U.S.C.C.A.N. 4639, 4650 ("The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws."). No other Circuit has adopted the treating physician rule in the ERISA context. No other Circuit has applied as searching a level of review based solely on the administration of the plan by the sponsor's employees. If the decision below is permitted to stand, plans covering employees in different States will be subject to conflicting rules.

The conflict among the Circuits is only exacerbated by ERISA's venue provision, which permits suit to be brought in any district where a defendant resides or may be found, or where the alleged breach took place, or where the plan is administered. *See* 29 U.S.C. § 1132(e)(2). It is not uncommon for an employer to find itself sued in a judicial district where it has never done business, simply because a former employee has moved or retired there. ERISA's permissive venue provision therefore invites forum shopping when the Circuits apply different interpretations of the statute, as they have here.

CONCLUSION

For all of these reasons, as well as those set forth in the petition, amicus respectfully urges the Court to grant the petition for certiorari to review both questions presented in this case.

Respectfully submitted,

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